Certificate of Live Birth

LOCAL FILE NUMBER

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF LIVE BIRTH

BIRTH NO. 147

SAMPLE

CHILD

CHILD'S NAME — FIRST	MIDDLE	LAST	SEX	DATE OF BIRTH (Mo. Day. Yr.)	HOUR
1			2	3a	3b

HOSPITAL NAME (If not in hospital, give street and number)	CITY, TOWN, OR LOCATION OF BIRTH	COUNTY OF BIRTH
4a	4b	4c

CERTIFIER

I certify that the stated information concerning this birth is true to the best of my knowledge and belief. 5a (Signature) ▶	DATE SIGNED (Mo. Day. Yr.)	NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)
	5b	5c
CERTIFIER NAME AND TITLE (Type or print)	MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP)	
5d	5e	

REGISTRAR	DATE RECEIVED BY REGISTRAR (Month, Day, Yr.)
6a (Signature) ▶	6b

MOTHER

MOTHER-MAIDEN NAME — FIRST	MIDDLE	LAST	AGE (At time of this birth)	STATE OF BIRTH (If not in U.S.A., name country)
7a			7b	7c

RESIDENCE-STATE	COUNTY	CITY, TOWN OR LOCATION	STREET & NUMBER OF RESIDENCE	INSIDE CITY LIMITS (Specify Yes or No)
8a	8b	8c	8d	8e

MOTHER'S MAILING ADDRESS— If same as above, enter Zip Code only
9

FATHER

FATHER-NAME — FIRST	MIDDLE	LAST	AGE (At time of this birth)	STATE OF BIRTH (If not in U.S.A., name country)
10a			10b	10c

I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. (Signature of Parent or other informant) 11a (Signature) ▶	RELATION TO CHILD
	11b

DEATH UNDER ONE YEAR OF AGE. Enter State File Number of death certificate for this child

MULTIPLE BIRTHS: enter State File Number for male(s) → LIVE BIRTH(S); FETAL DEATH(S)

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

RACE-MOTHER (eg. White, Black, American Indian, etc.) (Specify)	RACE-FATHER (eg. White, Black, American Indian, etc.) (Specify)	BIRTH WEIGHT	THIS BIRTH Single, twin, triplet, etc. (Specify)	IF NOT SINGLE BIRTH-Born first, second, third, etc. (Specify)	IS MOTHER MARRIED? (Specify yes or no)
12	13	14	15a	15b	16

PREGNANCY HISTORY (Complete each section)		EDUCATION-MOTHER (Specify only highest grade completed)		EDUCATION-FATHER (Specify only highest grade completed)	
		Elementary or Secondary (0-12)	College (1-4 or 5 +)	Elementary or Secondary (0-12)	College (1-4 or 5 +)
LIVE BIRTHS (Do not include this Child)	OTHER TERMINATIONS (Spontaneous and Induced)	17		17	

17a. Now living	17b. Now dead	17d. Before 20 Weeks	17e. After 20 Weeks	DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	MONTH OF PREGNANCY PRENATAL CARE BEGAN First, second, etc. (Specify)	PRENATAL VISITS Total Number (If none so state)	APGAR SCORE 1 min.	APGAR SCORE 5 min.
Number ____ None ☐	Number ____ None ☐	Number ____ None ☐	Number ____ None ☐	20	21a	21b	22a	22b

COMPLICATIONS OF PREGNANCY (Describe or write "none")	
23	

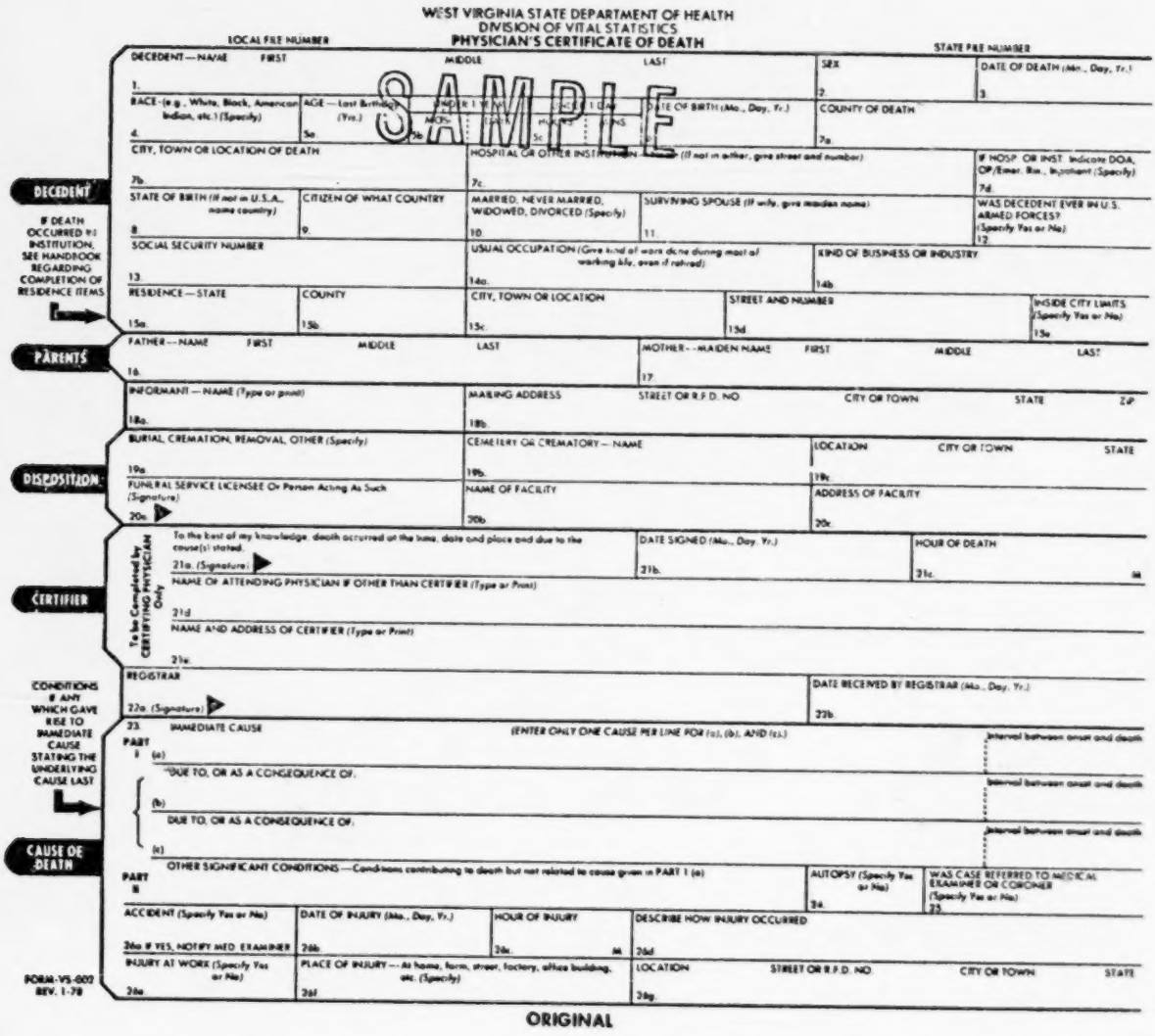
DATE OF LAST LIVE BIRTH (month, Year)	DATE OF LAST OTHER TERMINATION (all indicated in d or e above) (Month, Year)	CONCURRENT ILLNESSES OR CONDITIONS AFFECTING THE PREGNANCY (Describe or write "none")
17c	17f	24

COMPLICATIONS OF LABOR AND/OR DELIVERY (Describe or write "none")	CONGENITAL MALFORMATIONS OR ANOMALIES OF CHILD (Describe or write "none")
25	26

WAS SEROLOGIC TEST FOR SYPHILIS PERFORMED? Yes ☐ No ☐	If "yes" Date performed	NAME OF SEROLOGIC TEST	AT WHAT LABORATORY?	WAS APPROVED SOLUTION PLACED IN EYES? Yes ☐ No ☐
27a	27b	27d	27e	28
	If "no" state reason 27c			

ORIGINAL

Physician's Certificate of Death



WEST VIRGINIA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
PHYSICIAN'S CERTIFICATE OF DEATH

SAMPLE

LOCAL FILE NUMBER

STATE FILE NUMBER

DECEDENT

1. DECEDENT — NAME: FIRST / MIDDLE / LAST
2. SEX
3. DATE OF DEATH (Mo., Day, Yr.)
4. RACE - (e.g., White, Black, American Indian, etc.) (Specify)
5a. AGE — Last Birthday (Yrs.) — UNDER 1 YEAR: MONTHS / DAYS / HOURS / MINUTES
5b. DATE OF BIRTH (Mo., Day, Yr.)
5c.
7a. COUNTY OF DEATH
7b. CITY, TOWN OR LOCATION OF DEATH
7c. HOSPITAL OR OTHER INSTITUTION — NAME (If not in either, give street and number)
7d. IF HOSP. OR INST. Indicate DOA, OP, Emer. Rm., Inpatient (Specify)
8. STATE OF BIRTH (If not in U.S.A., name country)
9. CITIZEN OF WHAT COUNTRY
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
11. SURVIVING SPOUSE (If wife, give maiden name)
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No)
13. SOCIAL SECURITY NUMBER
14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
14b. KIND OF BUSINESS OR INDUSTRY
15a. RESIDENCE — STATE
15b. COUNTY
15c. CITY, TOWN OR LOCATION
15d. STREET AND NUMBER
15e. INSIDE CITY LIMITS (Specify Yes or No)

If death occurred in institution, see handbook regarding completion of residence items

PARENTS

16. FATHER — NAME: FIRST / MIDDLE / LAST
17. MOTHER — MAIDEN NAME: FIRST / MIDDLE / LAST

18a. INFORMANT — NAME (Type or print)
18b. MAILING ADDRESS: STREET OR R.F.D. NO. / CITY OR TOWN / STATE / ZIP

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify)
19b. CEMETERY OR CREMATORY — NAME
19c. LOCATION: CITY OR TOWN / STATE
20a. FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature)
20b. NAME OF FACILITY
20c. ADDRESS OF FACILITY

CERTIFIER

To be Completed by CERTIFYING PHYSICIAN Only

To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.
21a. (Signature)
21b. DATE SIGNED (Mo., Day, Yr.)
21c. HOUR OF DEATH
21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)
21e. NAME AND ADDRESS OF CERTIFIER (Type or Print)

22a. REGISTRAR (Signature)
22b. DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

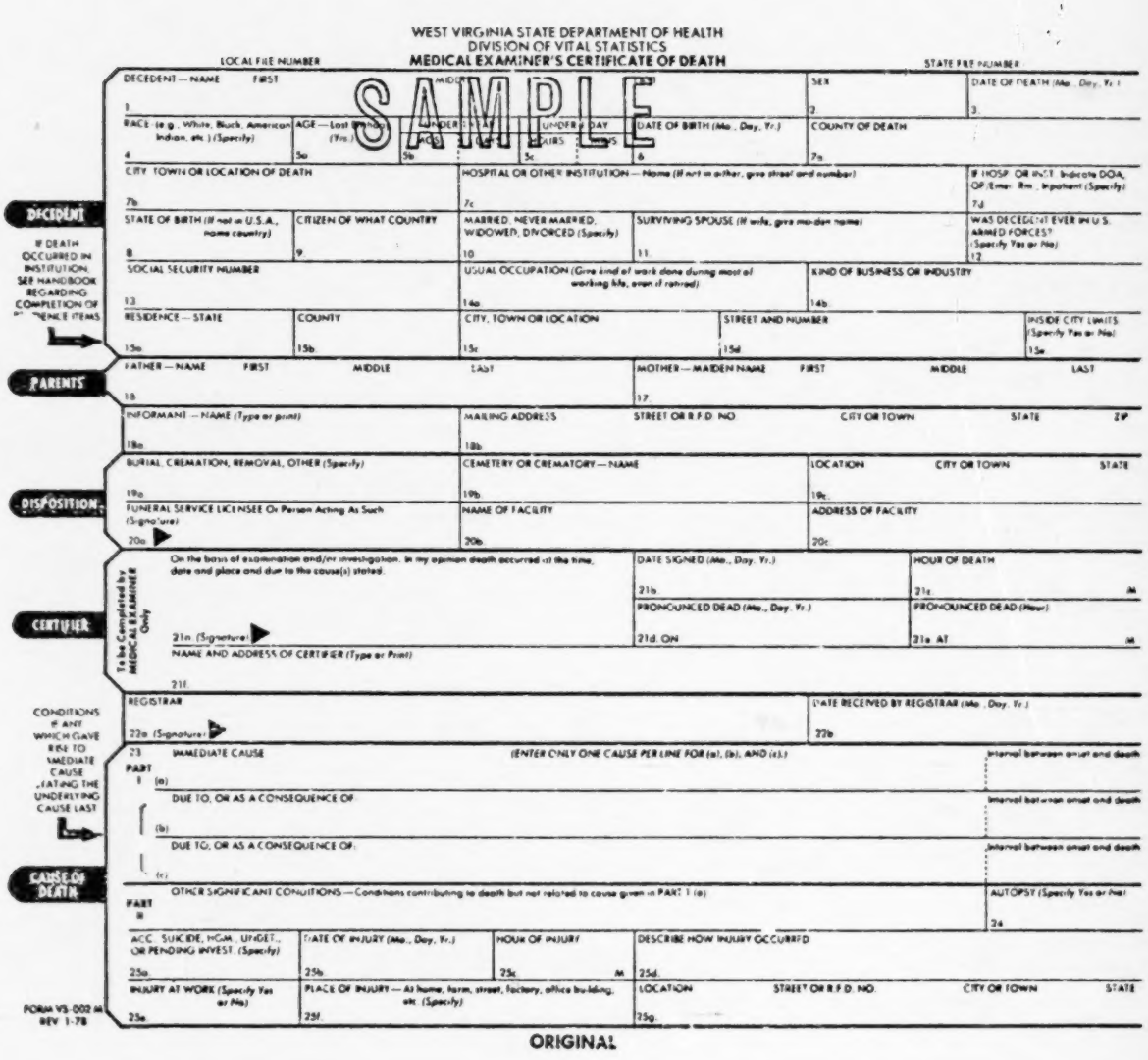
23. PART I — IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)
(a) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(b) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(c) — Interval between onset and death
PART II — OTHER SIGNIFICANT CONDITIONS — Conditions contributing to death but not related to cause given in PART I (a)
24. AUTOPSY (Specify Yes or No)
25. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No)

26a. ACCIDENT (Specify Yes or No) — IF YES, NOTIFY MED. EXAMINER
26b. DATE OF INJURY (Mo., Day, Yr.)
26c. HOUR OF INJURY
26d. DESCRIBE HOW INJURY OCCURRED
26e. INJURY AT WORK (Specify Yes or No)
26f. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26g. LOCATION: STREET OR R.F.D. NO. / CITY OR TOWN / STATE

FORM VS-002 REV. 1-78

ORIGINAL

Medical Examiner's Certificate of Death



WEST VIRGINIA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

SAMPLE

DECEDENT — NAME (First, Middle, Last) 1

SEX 2

DATE OF DEATH (Mo., Day, Yr.) 3

RACE (e.g., White, Black, American Indian, etc.) (Specify) 4

AGE — Last Birthday (Yrs.) 5a

UNDER 1 DAY — AGE — HOURS / MINUTES 5b 5c

DATE OF BIRTH (Mo., Day, Yr.) 6

COUNTY OF DEATH 7a

CITY, TOWN OR LOCATION OF DEATH 7b

HOSPITAL OR OTHER INSTITUTION — Name (If not in either, give street and number) 7c

IF HOSP. OR INST. Indicate DOA, OP, Emer. Rm., Inpatient (Specify) 7d

DECEDENT

STATE OF BIRTH (If not in U.S.A., name country) 8

CITIZEN OF WHAT COUNTRY 9

MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 10

SURVIVING SPOUSE (If wife, give maiden name) 11

WAS DECEDENT EVER IN U.S. ARMED FORCES? (Specify Yes or No) 12

If DEATH OCCURRED IN INSTITUTION, SEE HANDBOOK REGARDING COMPLETION OF [illegible] ITEMS

SOCIAL SECURITY NUMBER 13

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14a

KIND OF BUSINESS OR INDUSTRY 14b

RESIDENCE — STATE 15a

COUNTY 15b

CITY, TOWN OR LOCATION 15c

STREET AND NUMBER 15d

INSIDE CITY LIMITS (Specify Yes or No) 15e

PARENTS

FATHER — NAME (First, Middle, Last) 16

MOTHER — MAIDEN NAME (First, Middle, Last) 17

INFORMANT — NAME (Type or print) 18a

MAILING ADDRESS (Street or R.F.D. No., City or Town, State, Zip) 18b

DISPOSITION

BURIAL, CREMATION, REMOVAL, OTHER (Specify) 19a

CEMETERY OR CREMATORY — NAME 19b

LOCATION (City or Town, State) 19c

FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature) 20a

NAME OF FACILITY 20b

ADDRESS OF FACILITY 20c

CERTIFIER

To be Completed by MEDICAL EXAMINER Only

On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.

DATE SIGNED (Mo., Day, Yr.) 21b

HOUR OF DEATH 21c

21a. (Signature)

PRONOUNCED DEAD (Mo., Day, Yr.) 21d. ON

PRONOUNCED DEAD (Hour) 21e. AT

NAME AND ADDRESS OF CERTIFIER (Type or Print) 21f.

REGISTRAR 22a (Signature)

DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.) 22b

CAUSE OF DEATH

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (STATING THE UNDERLYING CAUSE LAST)

23 IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)

PART I (a)

Interval between onset and death

DUE TO, OR AS A CONSEQUENCE OF (b)

Interval between onset and death

DUE TO, OR AS A CONSEQUENCE OF (c)

Interval between onset and death

PART II OTHER SIGNIFICANT CONDITIONS — Conditions contributing to death but not related to cause given in PART I (a)

AUTOPSY (Specify Yes or No) 24

ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify) 25a

TIME OF INJURY (Mo., Day, Yr.) 25b

HOUR OF INJURY 25c

DESCRIBE HOW INJURY OCCURRED 25d.

INJURY AT WORK (Specify Yes or No) 25e

PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 25f.

LOCATION (Street or R.F.D. No., City or Town, State) 25g.

FORM VS-002 M REV 1-78

ORIGINAL

Certificate of Fetal Death

TYPE, OR PRINT IN PERMANENT INK See Handbook for Instructions

Dist. No. _____ Serial No. _____

WEST VIRGINIA STATE DEPARTMENT OF HEALTH—DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH

STATE FILE NO.

SAMPLE

FETUS

1. FETUS—NAME (First, Middle, Last)
2a. DATE OF DELIVERY (Month, Day, Year)
2b. HOUR (A.M.)
3. SEX
4a. THIS DELIVERY (Single, Twin, Triplet, Etc.) (Specify)
4b. IF NOT SINGLE DELIVERY born first, second, third, etc. (specify)
5a. COUNTY OF DELIVERY
5b. CITY, TOWN, OR LOCATION OF DELIVERY
5c. INSIDE CITY LIMITS (Specify yes or no)
5d. HOSPITAL—NAME (If not in hospital, give street and number)

MOTHER

6a. MOTHER—MAIDEN NAME (First, Middle, Last)
6b. AGE (at time of this delivery)
6c. STATE OF BIRTH (If not in U.S.A., name country)
7a. RESIDENCE—STATE
7b. COUNTY
7c. CITY, TOWN, OR LOCATION
7d. INSIDE CITY LIMITS (Specify yes or no)
7e. STREET AND NUMBER

FATHER

8a. FATHER—NAME (First, Middle, Last)
8b. AGE (at time of this delivery)
8c. STATE OF BIRTH (If not in U.S.A., name country)

CAUSE

9. PART I. FETAL DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) — SPECIFY FETAL OR MATERNAL

Fetal or maternal condition directly causing fetal death — IMMEDIATE CAUSE (a)

Fetal and/or maternal conditions, if any, giving rise to the immediate cause (a) stating the underlying cause last — (b) DUE TO, OR AS A CONSEQUENCE OF: (c) DUE TO, OR AS A CONSEQUENCE OF:

PART II. OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER: Conditions contributing to fetal death but not related to cause given in Part I (a)

10. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN (Specify)
11a. AUTOPSY (Specify yes or no)
11b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH

CERTIFIER

I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD
12a. SIGNATURE
12b. DATE SIGNED (month, day, year)
12c. ATTENDANT—M.D., D.O., midwife, other (specify)
12d. CERTIFIER—MAILING ADDRESS (Street or R.F.D. No., city or town, state, zip)
13. AUTHORIZED OFFICIAL (If delivery not attended by physician) SIGNATURE

BURIAL

14a. BURIAL, CREMATION, OR REMOVAL (Specify)
14b. CEMETERY OR CREMATORY—NAME
14c. LOCATION (City or town, state)
14d. DATE (Month, day, year)
15a. FUNERAL HOME—NAME AND ADDRESS (Street or R.F.D. No., city or town, state, zip)
15b. FUNERAL DIRECTOR—SIGNATURE
16a. REGISTRAR—SIGNATURE
16b. DATE RECEIVED BY LOCAL REGISTRAR (month, day, year)

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

FATHER

17. RACE—FATHER (White, Negro, American Indian, etc. (Specify))
18. EDUCATION—Specify highest grade completed (Elementary (0,1,2,3,4, . . . or 8); High School (1,2,3, or 4); College (1,2,3,4, or 5+))
19a. USUAL OCCUPATION
19b. KIND OF BUSINESS OR INDUSTRY

MOTHER

20. RACE—MOTHER (White, Negro, American Indian, etc. (Specify))
21. EDUCATION—Specify highest grade completed (Elementary (0,1,2,3,4, . . . or 8); High School (1,2,3, or 4); College (1,2,3,4, or 5+))
22a. USUAL OCCUPATION
22b. KIND OF BUSINESS OR INDUSTRY

MULTIPLE BIRTHS (Enter State File Number for Mate(s))

LIVE BIRTH(S)

FETAL DEATH(S)

23a. PREVIOUS DELIVERIES—HOW MANY OTHER CHILDREN ARE NOW LIVING
23b. WERE BORN ALIVE—NOW DEAD
23c. WERE BORN DEAD (Fetal death at any time after conception)
23d. DATE OF LAST LIVE BIRTH (Month, Day, Year)
23e. DATE OF LAST FETAL DEATH (Month, Day, Year)
24a. DATE LAST NORMAL MENSES BEGAN (Month, day year)
24b. MONTH OF PREGNANCY PRENATAL CARE BEGAN 1st, 2d, etc. (Specify)
24c. PRENATAL VISITS Total number (If none, so state)
25a. WAS SEROLOGIC TEST FOR SYPHILIS PERFORMED Yes ☐ No ☐
25b. IF "NO" STATE REASON
26. LEGITIMATE (Specify yes or no)
27. BIRTH WEIGHT lbs. ozs.
28. COMPLICATIONS RELATED TO PREGNANCY OR LABOR (Describe or write "none")
29. BIRTH INJURIES TO FETUS (Describe or write "none")
30. COMPLICATIONS NOT RELATED TO PREGNANCY OR LABOR (Describe or write "none")
31. CONGENITAL MALFORMATIONS OR ANOMALIES OF FETUS (Describe or write "none")

Form VS-003 (1-1-48)

Application for Marriage License

WEST VIRGINIA STATE DEPARTMENT OF HEALTH—DIVISION OF VITAL STATISTICS

APPLICATION FOR MARRIAGE LICENSE

License No. _____
License Issued: Date _____ County _____ State File No. _____

Write plainly with permanent ink or typewriter.

SAMPLE

GROOM

1. FULL NAME (First) (Middle) (Last) — 2. COLOR OR RACE
3. DATE OF BIRTH (Month) (Day) (Year) — 4. AGE (Last Birthday) _____ Years — 5. RELATIONSHIP TO BRIDE _____ None ☐
6. BIRTHPLACE (City or Town, State or Foreign Country) — 7. USUAL RESIDENCE Street & No. or Rur. Rte. / County — City or Town / State
8. PREVIOUS MARITAL STATUS — Never Married ☐ — LAST MARRIAGE ENDED BY: Death ☐ Divorce ☐ Annulment ☐ — 9. NUMBER OF PREVIOUS MARRIAGES _____ None ☐ — 10. EVIDENCE OF AGE
11. FATHER'S NAME — 12. MOTHER'S MAIDEN NAME

BRIDE

13. FULL NAME (First) (Middle) (Last) — 14. COLOR OR RACE
15. DATE OF BIRTH (Month) (Day) (Year) — 16. AGE (Last Birthday) _____ Years — 17. RELATIONSHIP TO GROOM _____ None ☐
18. BIRTHPLACE (City or Town, State or Foreign Country) — 19. USUAL RESIDENCE Street & No. or Rur. Rte. / County — City or Town / State
20. PREVIOUS MARITAL STATUS — Never Married ☐ — LAST MARRIAGE ENDED BY: Death ☐ Divorce ☐ Annulment ☐ — 21. NUMBER OF PREVIOUS MARRIAGES _____ None ☐ — 22. EVIDENCE OF AGE
23. FATHER'S NAME — 24. MOTHER'S MAIDEN NAME

The applicant(s), being first duly sworn, declares that the statements above are true and correct.

Bride and groom must sign. →

25. SIGNATURE OF GROOM — 26. SIGNATURE OF BRIDE

27. Taken, subscribed and sworn to before the undersigned authority by the applicant(s) above, this _____ day of _____ 19____

_____ County Clerk By _____

Deputy Clerk, County Court of _____ County, W. Va.

RECORD OF MARRIAGE

To County Clerk:
1. Transcribe information from marriage license to Record of Marriage.
2. Item 31: Enter date this record is completed.

28. DATE OF MARRIAGE (Month) (Day) (Year) — 29. COUNTY OF MARRIAGE — 30. CITY OR TOWN OF MARRIAGE

31. OFFICIANT'S A. NAME _____ B. ADDRESS _____

C. AUTHORIZED POSITION ☐ RELIGIOUS OFFICIAL _____ Specify Religious Body ☐ CIVIL OFFICIAL _____ Specify Authorized Position

32. SIGNATURE OF COUNTY CLERK — 33. DATE FILED (Month) (Day) (Year)

VS-008 (Rev. 7-1-65)

Monthly Report of Divorces and Annulments of Marriage Granted

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL STATISTICS

Page No. ____

MONTHLY REPORT OF DIVORCES AND ANNULMENTS OF MARRIAGE GRANTED

_____ COUNTY REPORT FOR THE MONTH OF _____, 19 ___

CIVIL ACTION NUMBER	NAME HUSBAND'S FULL NAME WIFE'S MAIDEN NAME	DATE OF BIRTH, OR AGE	PLACE OF THIS MARRIAGE COUNTY STATE	DATE OF THIS MARRIAGE	PLAINTIFF (SPECIFY)	DIVORCE OR ANNULMENT (SPECIFY)	NAME(S) CHILDREN UNDER EIGHTEEN	DATE OF THIS DECREE	DO NOT WRITE IN THIS SPACE

SAMPLE

DVS-9 (5-'67)

(SEE REVERSE SIDE FOR INSTRUCTIONS AND CERTIFICATION)

APPENDIX B GROUPINGS OF ICDA CODES

I.C.D.A.	SELECTED CAUSES
001-009	Intestinal infectious diseases
010-018	Tuberculosis
038	Septicemia
140-208	Malignant neoplasms
150-159	--of digestive organs and peritoneum
160-165	--of respiratory and intrathoracic organs
179-189	--of genitourinary organs
210-239	Benign neoplasms, carcinoma in situ, and neoplasms of uncertain behavior and of unspecified nature
250	Diabetes mellitus
260-269	Nutritional deficiencies
280-285	Anemias
390-448	Major cardiovascular diseases
390-398, 402-404-429	Diseases of the heart
401-403	Hypertension with or without renal disease
430-438	Cerebrovascular diseases
440	Arteriosclerosis
441-448	Other diseases of arteries, arterioles, and capillaries
480-487	Pneumonia and influenza
480-486	Pneumonia
487	Influenza
490-496	Chronic obstructive pulmonary disease and allied conditions
490-493	Bronchitis, emphysema, and asthma
500-508	Pneumoconiosis and other lung diseases due to external agents
500	Coalworker's pneumoconiosis
531-533	Ulcer of stomach and duodenum
550-553, 560	Hernia of abdominal cavity and intestinal obstruction
571	Chronic liver disease and cirrhosis
574-575	Cholelithiasis and other disorders of gallbladder
580-589	Nephritis, nephrotic syndrome, and nephrosis
590	Infection of kidney
740-759	Congenital anomalies
760-779	Certain conditions originating in the perinatal period
767-769	Birth trauma, intrauterine hypoxia, birth asphyxia, and respiratory distress syndrome
765	Disorders relating to short gestation and unspecified low birth weight
780-799	Symptoms, signs, and ill-defined conditions
E800-E949	Accidents, all forms
E810-E825	Motor vehicle accidents
	Home accidents
	Work accidents
E950-E959	Suicide
E960-E969	Homicide
Residual Codes	All other causes